Children's Mental Health Waiver

Provider Procedure for: Planning and Development of Quarterly Individual Service Plans

Implementation Date: 7/1/06

Revision Date: 9/1/07

Overview

Development of the Quarterly Individual Service Plan (ISP) is a process that brings together the youth/family, their identified support persons, and the Family Care Team to accomplish the following:

- Evaluate the current Individual Service Plan to identify which services and supports continue to focus
 on youth and family's strengths, preferences, and goals and promote continued efforts toward
 success.
- Establish reasonable and meaningful goals for the next three-month period for waiver services.
- Design or re-design individualized supports and services to address the identified needs and build on and enhance the youth and family's strengths and successes achieved in previous ISPs.
- Begin discussion and focus efforts on transition planning.
- Achieve agreement and understanding about who is responsible for identified tasks and within what specific time frames.

An Individual Service Plan development meeting is never to be held without involvement and participation of the youth and family. Other non-waiver Family Care Team members may send a representative to a Team meeting but that person must come prepared to fully participate in the planning process, to discuss services being provided, and commit the person he/she represents to service provision as identified by the Family Care Team.

The Quarterly ISP process is designed to report changes, document progress, and evaluate the current status of services and supports and the Team's plans to continue, modify, or discontinue those in line with the current preferences, needs, and goals of the youth and family.

Waiver Provider Roles and Responsibilities

Family Care Coordinator will:

- Work with the youth and family to identify any changes they wish to make in their identified family support persons, waiver providers, and other Family Care Team members (Mental Health Therapist/Counselor, Representative from Education, Representative from DFS, and others based on current involvement with youth/family).
 - o Complete Choice of Provider form (WP-10) to reflect any changes made.
- Discuss with the youth and family and members of the Family Care Team any request/need for completion of new or follow-up assessments/evaluations.
 - Contact Team Members to request a new or follow-up assessment/evaluation.
- Facilitate level of care re-evaluations following program schedule and time lines (Refer to Provider Procedure for *Level of Care Re-Evaluation*).
- Work with the youth and family to set a meeting date and location for the ISP.
- Review the quarterly planning meeting process with the youth, family, and family support persons to explain the meeting format, what information the youth and family will be asked to share, what decisions they will be asked to make and participate in, and what supports they need in order for them to participate in the meeting at a level they are most comfortable with.
 - An outline is available to facilitate this review included in this section of the Provider Procedure Manual.

- This step may be modified to focus on supports requested by the youth and family to increase their level of participation in the planning meetings – with encouragement and advocacy directed toward increasing independence.
- Completion of this step for subsequent plans is at the discretion of the Family Care Coordinator and as changes to family support persons warrant.
- Send out written meeting notification to Family Care Team members and family support persons <u>at least 14 days prior to the meeting date</u>.
 - As applicable, include a reminder to Family Care Team members identified to submit assessment/evaluation reports.
 - o A copy of the written notification will be maintained in the youth's waiver record/file.
- If new or follow-up assessments/evaluations are requested:
 - If applicable, set up time with youth and family to complete the identified assessment/evaluation (FCC-4 and/or FCC-5) – must be completed at least 5 days before the meeting date.
 - Monitor receipt of written assessment/evaluation reports from identified Family Care Team members (FCT-5) - must be received at least 5 days before the meeting date.
 - Review assessment/evaluation reports to identify and gather information re: needs and service recommendations – <u>must be completed before planning meeting</u>. (Completion of FCC-8 – Optional)
 - Provide access to reports upon request of youth/family, family support persons, and other Family Care Team members.
- Work with the youth and family to discuss and update the following sections of the ISP draft document.
 - Demographics
 - o Rights and responsibilities (Review and answer questions)
 - Medical Information
 - Medications
 - Strengths and preferences within life domains (This should also be reflected in assessments and evaluations completed by each member of the Family Care Team).
 - Elicit feedback relating to the current focus of services and supports and any changes they would like to see.
 - Elicit feedback on continued need for a behavior support plan and any changes in focus that should be discussed and considered.
 - o Identify the use of or continued need for current and/or other Medicaid mental health and medical services.
- As needed, contact psychotropic medication prescriber to gather any missing information outlined in the Medications section of the ISP document.
- Facilitate planning meeting and advocate for the youth and family's involvement and decision-making.
 - The goal of the Family Care Team continues to focus on the development of a coordinated and individualized service plan, with increasing involvement and decision-making by the youth and family, which continues to build on the youth and family's strengths and preferences to address their needs and support their desired vision.
 - Quarterly ISPs also focus on transition planning efforts. (Refer to Transition for Waiver Discharge procedure).
 - Involvement by the family support persons should continue to be supported and elicited as they
 will be a valuable resource to the youth/family in plan implementation.
- Develop the ISP budget based on calculations of the duration and frequency of ALL services that will be provided to the youth and family.
 - Services and supports may be continued with possible changes in duration and/or frequency (increase or decrease).
 - Services and supports may be modified to change the focus or approach provided in response to positive or negative changes in the youth/family's circumstances.

- Services and supports may be completed or discontinued with new services and supports identified to take their place.
 - The need for Family Training and Support, Individualized Youth Training and Support, Respite Care, and mental health and medical services will be identified through the planning process.
- Calculations are based on the upcoming three-month time period.
 - Identify and calculate the duration (# of 15 minute-service units) and frequency (# times per week or month) the chosen waiver services will be provided over the next three months.
 - Consideration must be given to any identified service limits.
 - If the youth and family request and the Team is in agreement that more than the allowable units are needed for the ISP, an Exceptional Service Plan request should be submitted.
 - Next, review the list of Medicaid Covered Mental Health services to identify and calculate the number of service units and the frequency that the service(s) will be provided for the next three months.
 - This information should be proposed by the Mental Health professional and agreed upon by the youth and family.
 - Finally, review the Other Medicaid State Plan Medical Services to estimate and calculate, using previous three-month payment histories, medical services that may be needed and used over the next three months.
- The total of the waiver and mental health calculations will be the identified service budget amount for the Individual Service Plan.
 - If this total is more than \$7,000, the Family Care Team should consider this as an "Exceptional Service Plan" and the Provider Procedure re: Exceptional Service Plan Requests should be implemented.
 - Questions regarding this process can be researched in related provider procedures outlined in the manual or directed to Waiver Program staff.
- Utilize first the Initial Individual Service Plan document (WP-1) approved by the Waiver Program and then subsequent approved Quarterly ISP documents, save as the applicable quarterly ISP document, and follow these guidelines to complete:
 - Review clinical, non-clinical waiver, medical and natural services and supports with new areas of focus identified through development of new outcome objectives and behavior support plans.
 - Continue to ensure that the information and level of detail documented in the ISP supports involvement and participation of ALL Family Care Team members.
 - Be specific to paint a picture of what service provision is to look like.
 - Be specific in identifying available resources for Family Care Team members.
 - Plan start and end dates for the quarterly Individual Service Plan must stay within the current quarter and no more than one day from the previous plan end date to ensure no gaps in service are created.
 - Example: Quarterly ISP start date = 5/6/07 End Date = no later than 8/5/07

The Quarterly Individual Service Plans are designed to allow for ongoing updates and status reports of progress made on identified outcome objectives.

- As noted above, the Initial ISP document should be used and saved as the applicable quarterly
 plan version to allow the most current document to reflect <u>all</u> planning and service provision.
- Information should be reviewed and updated as needed with the change noted as such and the date of the change included in the information provided.
 - Update plan to include any service plan modifications made during the previous quarter.
 - Add changes to applicable sections of the ISP document and include date of implementation.

• If no change is noted, it is the assumption that the information is current and ongoing in the current plan.

Under the identified Outcome Objectives, please follow these guidelines to reflect progress reporting:

- Action Steps and Anticipated Completion Dates Identify as "met", "continued", "discontinued", or "rewritten" with the completion date noted.
- Responsible Person and Type of Support Note name of individual and type of support and date the change was made.
- Duration/Frequency Note change and date the change was made.
- Method for Monitoring and Measuring Note change and date the change was made.
- Projected date for completing Outcome Objective Identify as "met", "continued", "discontinued", or "rewritten" with the completion date noted.
- Updates are documented with the date of the information provided and a summary of work being done, progress/lack of progress and actions taken by the Team to address successes, barriers, etc.
 - Subsequent updates are documented in the same format in chronological order until the Outcome Objective is completed or discontinued.

Under the Team Meeting Minutes section, document status reports for the following:

- Transition Planning beginning with 2nd Quarterly ISP and all subsequent plans thereafter.
- Exceptional Service Plan Request at 1st ISP following approved request and all subsequent plans thereafter as long as request is in place.
- Utilize the "ISP Review Criteria Worksheet (FCC-16) and review the final draft ISP document against these criteria.
 - Additional information and/or identified corrections should be addressed prior to submitting the plan document to the Waiver Program.
 - Work with the youth/family and/or Family Care Team members as needed to obtain additional information or make needed corrections.
- Submit ISP to Waiver Program for review and approval, providing additional information as requested.
 - Submission of the final draft ISP must be done within 14 days of the identified plan start date.
 - o The plan may be submitted via fax, e-mail, or regular mail.
 - If the plan is submitted electronically, all handwritten and signature pages must be submitted via fax or regular mail.
 - Requests from the Waiver Program for additional clarification or information must be submitted within at least 1 day prior to the plan start date.
 - When all requested information has been received, Waiver staff will approve and sign the Individual Service Plan.
 - The original approved plan will be mailed to the Family Care Coordinator.
 - The plan may also be faxed prior to mailing this decision will be made based on the date of approval and the plan start date.
- Share copies of final approved ISP with youth/family, family support persons, and Family Care Team members as identified on the Plan Development Team page of the ISP document.
 - This task should be completed as soon as possible after receipt of the approved plan to support Family Care Team members in timely implementation of assigned outcome objectives and/or behavior support plans.

Waiver Service Providers will:

- Prepare for planning meeting by:
 - Evaluating services provided
 - Formulating recommendations for continuation, modification, or discontinuation based on evaluation findings
 - Requesting input and feedback from the youth/family and family support persons (if possible) to learn how services might be more effectively designed and implemented.
- Contact Family Care Coordinator to review assessment/evaluation reports of Family Care Team members prior to the ISP meeting.
- Participate in planning meeting to report service evaluation findings; make recommendations; and elicit feedback from Family Care Team on overall service provision plan.
- Implement assigned Service Objectives (FCT-1) and/or Behavior Support Plans (FCT-6) as agreed upon on the planning meeting.

Other Family Care Team Members will:

- As requested, meet with the youth and family to gather information and understanding to complete a written Family Care Team Assessment Report (FCT-5).
 - These reports will be submitted to the Family Care Coordinator within at <u>least 5 days prior to the scheduled meeting date.</u>
- Contact Family Care Coordinator to review assessment/evaluation reports of Family Care Team members prior to the ISP meeting.
- Participate in planning meeting to report service evaluation findings; make recommendations; and elicit feedback from Family Care Team on overall service provision plan.
- Implement assigned Service Objectives (FCT-1) and/or Behavior Support Plans (FCT-6) as agreed upon on the planning meeting.